| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295083 | A. BUILDING _____ B. WING _____ | C 01/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEIGHTS OF SUMMERLIN, LLC | 10550 PARK RUN DRIVE LAS VEGAS, NV 89144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted at your facility on January 6, 2015, in accordance with CFR (Code of Federal Regulations) 42, Chapter IV, Part 483, Requirements for Long Term Care Facilities.<br><br>The census on the day of the investigation was 184.<br><br>The sample size was 11 residents.<br><br>The complaint investigative process was initiated by the Division of Public and Behavioral Health on January 6, 2015<br><br>Complaint #NV00041374: The complaint was unsubstantiated.<br><br>The allegations included: 1) The facility failed to return medication to a resident at discharge, and 2) The facility caused a pressure sore.<br><br>1) The allegation the facility failed to return medication to a resident at discharge was unsubstantiated via interview with the Director of Nursing, a nursing shift supervisor, and a page by page review of the entire medical record.<br><br>2) The allegation the facility caused a pressure sore was unsubstantiated based on interview with the Director of Nursing and the treatment nurse, and review of the discharge summary from the previous facility, the nursing admission assessment, the treatment nurse assessment, and the wound care treatment records for the resident's other wounds. | F 000 | F000<br>This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Heights of Summerlin, LLC agrees with the allegations and citations listed on the statement of deficiencies The Heights of Summerlin, LLC maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Heights of Summerlin, LLC's written credible allegation of compliance.<br><br>By submitting this plan of correction, The Heights of Summerlin, LLC does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation or position, and The Heights of Summerlin, LLC reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/27/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
JAN 27 2015
BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295083 | A. BUILDING _____ B. WING _____ | C 01/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEIGHTS OF SUMMERLIN, LLC | 10550 PARK RUN DRIVE LAS VEGAS, NV 89144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br><br>Complaint #NV00041416: The complaint was unsubstantiated.<br><br>The complaint investigative process was initiated by the Division of Public and Behavioral Health on January 6, 2015<br><br>The allegation the facility failed to properly execute bed hold notices was unsubstantiated based on interview with the Medical Records Director and the Director of Nursing, review of admission and transfer files for bed hold documentation, and the bed hold guidelines.<br><br>Complaint #NV00041437: The complaint was substantiated.<br><br>The complaint investigative process was initiated by the Division of Public and Behavioral Health on January 6, 2015<br><br>The allegations included: 1) The facility failed to properly diagnose, treat and monitor residents receiving psychotropic medication, 2) The facility lacked diapers and linen, 3) The facility caused a resident's skin tear by an unsafe transfer.<br><br>1) The allegation the facility failed to properly diagnose, treat, and monitor residents receiving psychotropic medication was substantiated based on review of diagnostic information, the physician orders list for psychotropics, quarterly reviews of psychotropic use, medication administration records, psychotropic consents, and Behavior Management Policy dated 12/31/10. See Tag #329.<br><br>2) The allegation the facility lacked diapers and | F 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295083 | A. BUILDING _____ B. WING _____ | C 01/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEIGHTS OF SUMMERLIN, LLC | 10550 PARK RUN DRIVE LAS VEGAS, NV 89144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 2<br>linen was unsubstantiated based on observations within the facility.<br><br>3) The allegation the facility caused a resident's skin tear with an unsafe transfer was unsubstantiated based on review of self reports, the resident's treatment record, and nursing notes.<br><br>The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. | F 000 | | |
| F 329 SS=D | The following regulatory deficiency was identified:<br>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295083 | A. BUILDING _____ B. WING _____ | C 01/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEIGHTS OF SUMMERLIN, LLC | 10550 PARK RUN DRIVE LAS VEGAS, NV 89144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 3<br>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interview and policy review, the facility failed to conduct quarterly reviews of psychotropic medication use for 2 of 11 residents (Resident #1 and Resident #6), and failed to obtain a consent for psychotropic medication administration for 1 of 11 residents (Resident #11).<br><br>Findings include:<br><br>Resident #1<br><br>On 9/14/06, Resident #1 was admitted with coronary atherosclerosis, and on 7/23/13, Resident #1 was readmitted with diagnoses of coronary atherosclerosis and cardiac dysrhythmias, and dementia with confusion.<br><br>On 11/5/13, a physician ordered Celexa 10 milligrams daily for depression. The medical record showed Resident #1 received Celexa at the time of the on site visit.<br><br>Resident #1's medical record contained one quarterly psychoactive medication review dated 11/24/14.<br><br>On 1/6/15 in the afternoon, the Director of Nursing indicated there were no other completed | F 329 | **F329 (D) 483.25 (I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Residents #1, #6 and #11 remain to be in the facility.<br><br>Residents #1 remains to be on Celexa. A psychoactive medication review will be completed within 14 days (February 5, 2015). | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295083 | A. BUILDING _____ B. WING _____ | C 01/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEIGHTS OF SUMMERLIN, LLC | 10550 PARK RUN DRIVE LAS VEGAS, NV 89144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 4<br>reviews in the medical record.<br><br>According to the facility's policy Behavior Management (effective 12/31/10), "...Procedure...9. Following the admission, quarterly, annually, change in condition and as needed, the team will re-evaluate the effectiveness of non-drug interventions, the need for psychotropic medication, possible alternative(s) to use of psychotropic interventions ..."<br><br>Resident #6<br><br>On 10/26/06, Resident #6 was admitted with psychosis, and on 11/30/10, Resident #6 was readmitted with diagnoses of psychosis, muscle disuse atrophy, bipolar disorder, and schizophrenia.<br><br>On 8/4/13, a physician ordered Zyprexa 10 milligrams daily for Schizo-affective disorder.<br><br>On 8/14-15/13, a physician ordered Xanax 0.25 milligrams daily at 9:00 AM and 0.50 milligrams twice daily at noon and bed time for anxious feelings.<br><br>On 8/1/14, a physician ordered Lexapro 10 milligrams daily for depression.<br><br>The medical record showed Resident #1 received Zyprexa, Xanax, and Lexapro at the time of the on site visit.<br><br>Resident #1's medical record contained one quarterly psychoactive medication review dated 11/24/14. | F 329 | Resident #6 remains to be on Zyprexa, Xanax and Lexapro. A psychoactive medication review will be completed within 14 days (February 5, 2015).<br><br>Resident #11 remains on Restoril. A consent had been obtained on January 10, 2015 for the use of the medication.<br><br>**How will you identify other residents having the potential to be affected by the same practice:**<br><br>The facility will audit residents' charts by February 22, 2015. This is to ensure consents are being obtained for psychotropic medication usage and quarterly reviews are being conducted and completed.<br><br>The nursing staff will be in-serviced by February 5, 2015 regarding needed consents for use of any psychotropic medications.<br><br>The Social Services department will be in-serviced by February 5, 2015 regarding needed quarterly psychotropic medication reviews. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295083 | A. BUILDING _____ B. WING _____ | C 01/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEIGHTS OF SUMMERLIN, LLC | 10550 PARK RUN DRIVE LAS VEGAS, NV 89144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 5<br><br>On 1/6/15 in the afternoon, the Director of Nursing indicated there were no other completed reviews in the medical record.<br><br>Resident #11<br><br>On 7/12/14, Resident #11 was admitted with a diagnosis of chest pain, and on 8/18/14, Resident #11 was readmitted with diagnoses of chest pain, shortness of breath, difficulty walking, muscle disuse atrophy, encephalopathy, and moderate dementia.<br><br>On 8/26/14, a physician ordered Restoril 30 milligrams as needed at bed time for insomnia. The January 2015 medication administration record showed Resident #11 received Restoril each night at 9:00 PM for January 1-5.<br><br>On 1/6/15 at 2:45 PM in the afternoon, Resident #11's medical record lacked a psychotropic consent for Restoril administration. The Director of Nursing indicated there was no psychotropic consent for Restoril administration in the medical record.<br><br>According to the facility's policy, Behavior Management (effective 12/31/10), "...Procedure...3. Whenever an order is obtained for psychotropic medication (s), the licensed nurse verifies that informed consent has been obtained..."<br><br>Complaint #NV00041437 | F 329 | **What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur:**<br><br>A monthly audit of charts will be conducted and completed for every unit to ensure the deficiency will not recur.<br><br>**How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:**<br><br>Facility will monitor corrective action during the QAA meetings for the next 4 months to assure that the deficient practice will not recur. When results are in compliance, the facility will monitor at QAA quarterly.<br><br>**Individual Responsible: Director of Social Services**<br>**Date of Completion: February 20, 2015** | |